

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Barnett Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Star Route 40</u> c. LENGTH OF STAY IN 1b <u>Instant</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Frostburg</u> d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Earl</u> First <u>Harvey</u> Middle <u>Caton</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1-1939</u>	9. AGE (In years last birthday) <u>21</u> yrs.	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seaboard Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>Finzel Road</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Earl C. Caton</u>			14. MOTHER'S MAIDEN NAME <u>Nannie Albright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>202-34-1723</u>		17. INFORMANT <u>Mrs. Pearl Garlitz</u> Address _____		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>816X</u> DUE TO (b) <u>Hemothorax, Abdominal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Ruptured Lung, right, Ruptured liver</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>15 min</u> <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right arm</u>						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto collision</u>				
20c. TIME OF INJURY Month, Day, Year <u>9:00 a.m. Mar. 5 1960</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. #40</u>		
20f. (City or town) <u>6mi. W. of Frostburg, All. Md.</u>		20g. (County) _____ (State) _____				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE <u>James H. Fenster, M.D.</u> EXAMINER'S NAME (Type) <u>James H. Fenster, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-5-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Johnson</u>		
22d. LOCATION (City, town, or county) <u>Barnett Co.</u>		(State) _____				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. D. Frostburg, Md.</u>			24a. REC'D BY REGISTRAR <u>DATE MAR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STANDARD STATE DEPARTMENT OF HEALTH - ILLINOIS 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Officer		15. Signature of Registrar	
16. Signature of Cemetery		17. Signature of Funeral Home		18. Signature of Other	
19. Signature of Other		20. Signature of Other		21. Signature of Other	
22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other	
28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other	
34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other	
40. Signature of Other		41. Signature of Other		42. Signature of Other	
43. Signature of Other		44. Signature of Other		45. Signature of Other	
46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other	
52. Signature of Other		53. Signature of Other		54. Signature of Other	
55. Signature of Other		56. Signature of Other		57. Signature of Other	
58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other	
64. Signature of Other		65. Signature of Other		66. Signature of Other	
67. Signature of Other		68. Signature of Other		69. Signature of Other	
70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other	
76. Signature of Other		77. Signature of Other		78. Signature of Other	
79. Signature of Other		80. Signature of Other		81. Signature of Other	
82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other	
88. Signature of Other		89. Signature of Other		90. Signature of Other	
91. Signature of Other		92. Signature of Other		93. Signature of Other	
94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other	
100. Signature of Other		101. Signature of Other		102. Signature of Other	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			c. LENGTH OF STAY IN 1b <u>minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oakland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Liberty St. Ext.</u>				d. STREET ADDRESS <u>Liberty St. Ext</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Collins</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1876</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stone mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Penn. chance, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Collins</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bosley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>614-32-3066</u>		17. INFORMANT <u>Priscilla Shaffer</u> Address <u>Oakland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis, generalized</u> (c) <u> </u> (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		3-9-60	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Winnich Funeral Home</u>				ADDRESS <u>Oakland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Flann</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained in your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swanton</u>			c. LENGTH OF STAY IN 1b <u>55 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swanton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>L.</u> Last <u>McRobie Custer</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> , Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 27, 1899</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John W. McRobie</u>				14. MOTHER'S MAIDEN NAME <u>Stella Rodeheaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-36-9411</u>		17. INFORMANT Address <u>Ray R. Custer Swanton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-25-60</u>			
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North Glade Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Swanton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. L. Leighton</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>				24c. REGISTRAR'S SIGNATURE _____			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7524

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the registrars 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3331

CERTIFICATE OF DEATH

03299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA. b. COUNTY TUCKER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, MARYLAND		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS DAVIS,	
3. NAME OF DECEASED (Type or print) First AGNES Middle BELL Last EVANS		4. DATE OF DEATH Month MARCH Day 6 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1894
9a. AGE (In years last birthday) 65 yrs.		9b. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MAYSVILLE, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOE MC GRAW		14. MOTHER'S MAIDEN NAME PEARL EVERLY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Homer Evans		Address Davis, W.Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 199. 2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tubercle, Pancreatic, Secondary, DUE TO to a. (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December, 1959 , to March 6, 1960 , that I last saw the deceased alive on March 6, 1960 , and that death occurred at 7:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alfred C. Cure, Jr. M.D.		ADDRESS (Street, city or town, state) March 8, 1960	
PHYSICIAN'S NAME (Type) DR. ALFRED CURE		AURORA, W. VA.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/9/60	22c. NAME OF CEMETERY OR CREMATORY Davis	22d. LOCATION (City, town, or county) (State) Davis, W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle		24a. REC'D BY REGISTRAR DAVID 10 '60	
ADDRESS Davis, W. VA.		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

CERTIFICATE OF DEATH

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

ALMA MATER

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3339

CERTIFICATE OF DEATH

03300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GAYLETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Galett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS RFD.	
3. NAME OF DECEASED (Type or print) First MARTIN - Middle - FALKNER Last - FALKNER		4. DATE OF DEATH Month Mar Day 17 Year 1960	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 14 1982
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Ind		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Ira		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Falkner		14. MOTHER'S MAIDEN NAME Martha Friend	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 236-01-9285	
17. INFORMANT Mrs Martin Falkner - Friendsville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY Arteriosclerosis (c) GENERALIZED Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA of PROSTATE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August, 1959 , to Dec, 1959 , that I last saw the deceased alive on Dec, 1959 , and that death occurred at 12:02 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Friendsville, MD DATE SIGNED Mar 17 60			
ACTUAL SIGNATURE Pedro Rivera		M.D. Friendsville, MD	
PHYSICIAN'S NAME (Type) PEDRO RIVERA			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 15 1960	
22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cem		22d. LOCATION (City, town, or county) (State) Friendsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Rodakaver		ADDRESS Markleysburg Pa	
24a. REC'D BY REGISTRAR MAR 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

00500

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VETERINARY MEDICINE

CERTIFICATE OF ANALYSIS

1933

Product

Lot

Analysis

1. *Staphylococcus aureus*

Franklin

2. *Staphylococcus aureus*

1/10

1/10

1/10

2/5

Analysis of *Staphylococcus aureus* 1/10

1/10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

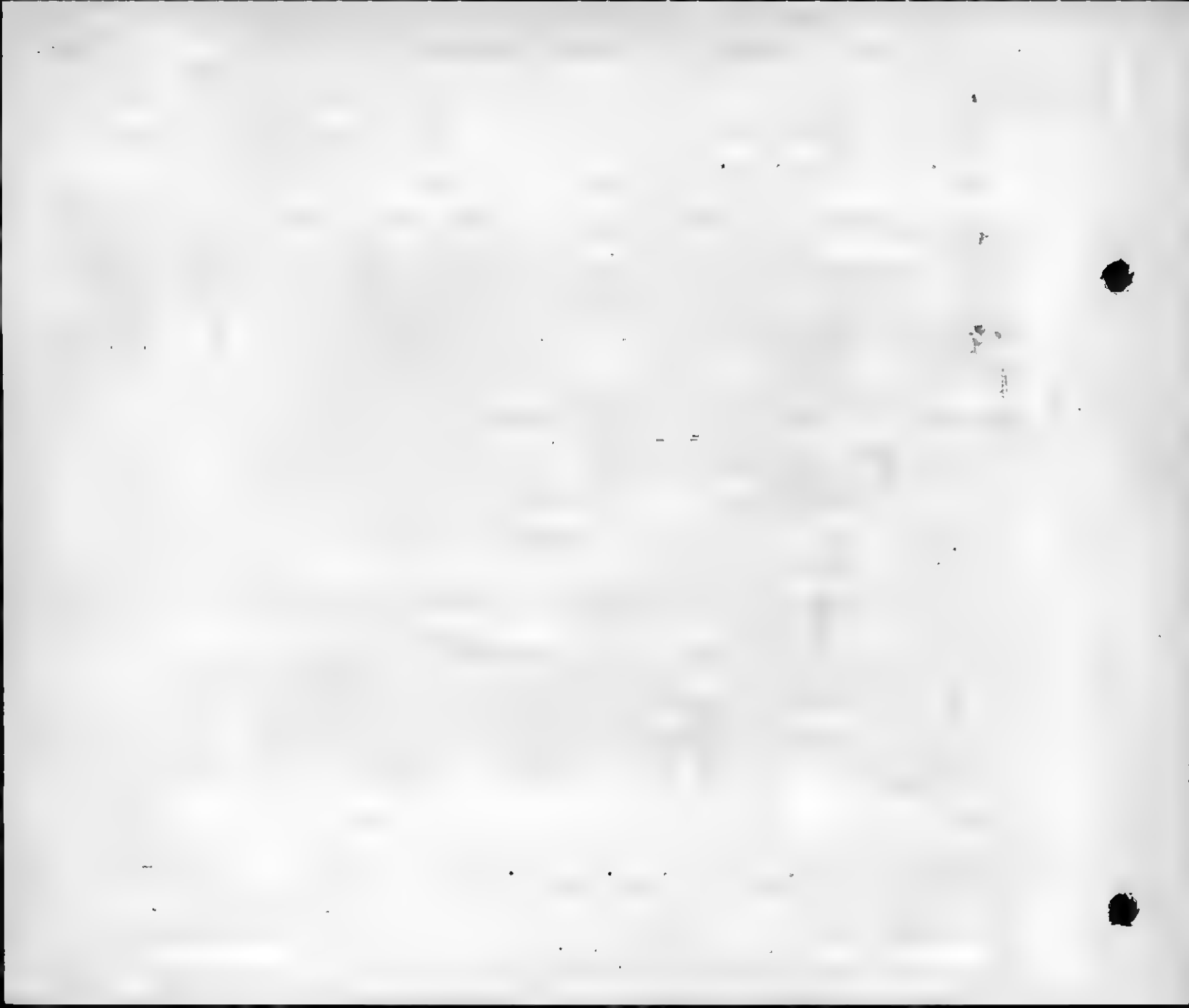
3349

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03301

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, Md.		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EGLON			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle T. Last FIKE				4. DATE OF DEATH Month MARCH Day 11 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 15, 1900	
9. AGE (in years last birthday) 59 yrs.		10. UNDER 1 YEAR Months 59 Days 11		11. UNDER 24 HRS. Hours 11 Min. 00		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman & Farmer				10b. KIND OF BUSINESS OR INDUSTRY Electrical Supplies		11. BIRTHPLACE (State or foreign country) EGLON, WEST VIRGINIA	
13. FATHER'S NAME JONAS FIKE				14. MOTHER'S MAIDEN NAME DELLA HAMSTEADZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 233-16-9485		17. INFORMANT J. ROGER FIKE, OAKLAND, MARYLAND.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) ***							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3-11-60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/14/60		22c. NAME OF CEMETERY OR CREMATORY Eglon Cemetery		22d. LOCATION (City, town, or county) (State) Eglon, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.R. Watson</i> P.R. WATSON, F.D. LICENSE A 7220				24a. REC'D BY REGISTRAR MAR 16 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kenna</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03302

3341

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BARRETT MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md b. COUNTY BARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D.		d. STREET ADDRESS R.F.D.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) ALICE - FRIEND - FRAZEE			4. DATE OF DEATH Mar 18 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 4-1913	9. AGE (In years last birthday) 46 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Keeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11 BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME Scott Friend			14. MOTHER'S MAIDEN NAME Ellen Raughter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Agnes Frazee - Friendsville Md	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS (c) Old Age		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 1959 to MARCH 1960 , that I last saw the deceased alive on MARCH 1960 , and that death occurred at 7:20 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Pedro Rivera M.D.	ADDRESS (Street, city or town, state) Friendsville, Md DATE SIGNED Mar 1960
PHYSICIAN'S NAME (Type) PEDRO RIVERA	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar 21-1960	22c. NAME OF CEMETERY OR CREMATORY Addison Cemetery	22d. LOCATION (City, town, or county) (State) Addison Pa.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Rodakauer - Markleysburg		24a. REC'D BY REGISTRAR DATE MAR 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kiana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3342

CERTIFICATE OF DEATH

03303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE md b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 1b all life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville md		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Friendsville md				1d STREET ADDRESS R.F.D. 2			
3. NAME OF DECEASED (Type or print) HAROLD - DAVID - FRIEND				4. DATE OF DEATH MAR - 1 - 1960			
5. SEX M.	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 26 - 1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY agriculture		11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David H. Friend				14. MOTHER'S MAIDEN NAME Mary Gary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. 214-24-2274		17. INFORMANT Mrs. Ruth Friend		Address Friendsville, md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left Ventricular Failure							
4700 DUE TO (b) Arteriosclerotic Heart Disease							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Sept , 1958, to Feb 29 , 1960, that I last saw the deceased alive on 2-29 , 1960, and that death occurred at 8:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Pedro Rivera				ADDRESS (Street, city or town, state) Friendsville, md		DATE SIGNED Mar 2 - 1960	
PHYSICIAN'S NAME (Type) PEDRO RIVERA							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 3 - 60		22c. NAME OF CEMETERY OR CREMATORY Sand Spring		22d. LOCATION (City, town, or county) (State) Friendsville md	
23. FUNERAL DIRECTOR'S SIGNATURE H. Rodenhauer				ADDRESS Markleysburg Pa		24a. REC'D BY REGISTRAR MAR 7 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

The following are the names of the persons who have been
 named in the above mentioned cases, and the date of their
 death, as far as known:

Name	Date of Death
John A. Smith	Jan. 10, 1897
James H. Brown	Feb. 15, 1897
William C. Jones	Mar. 20, 1897
Robert L. White	Apr. 25, 1897
Thomas M. Black	May 30, 1897
Charles K. Green	June 10, 1897
Edward F. Hall	July 15, 1897
George W. Adams	Aug. 20, 1897
Henry J. Baker	Sep. 25, 1897
Franklin D. Miller	Oct. 30, 1897
Samuel R. Wilson	Nov. 10, 1897
Benjamin S. Moore	Dec. 15, 1897

1. *Chrysomelidae* (Colorado potato beetle)
 2. *Curculionidae* (Colorado potato beetle)
 3. *Curculionidae* (Colorado potato beetle)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

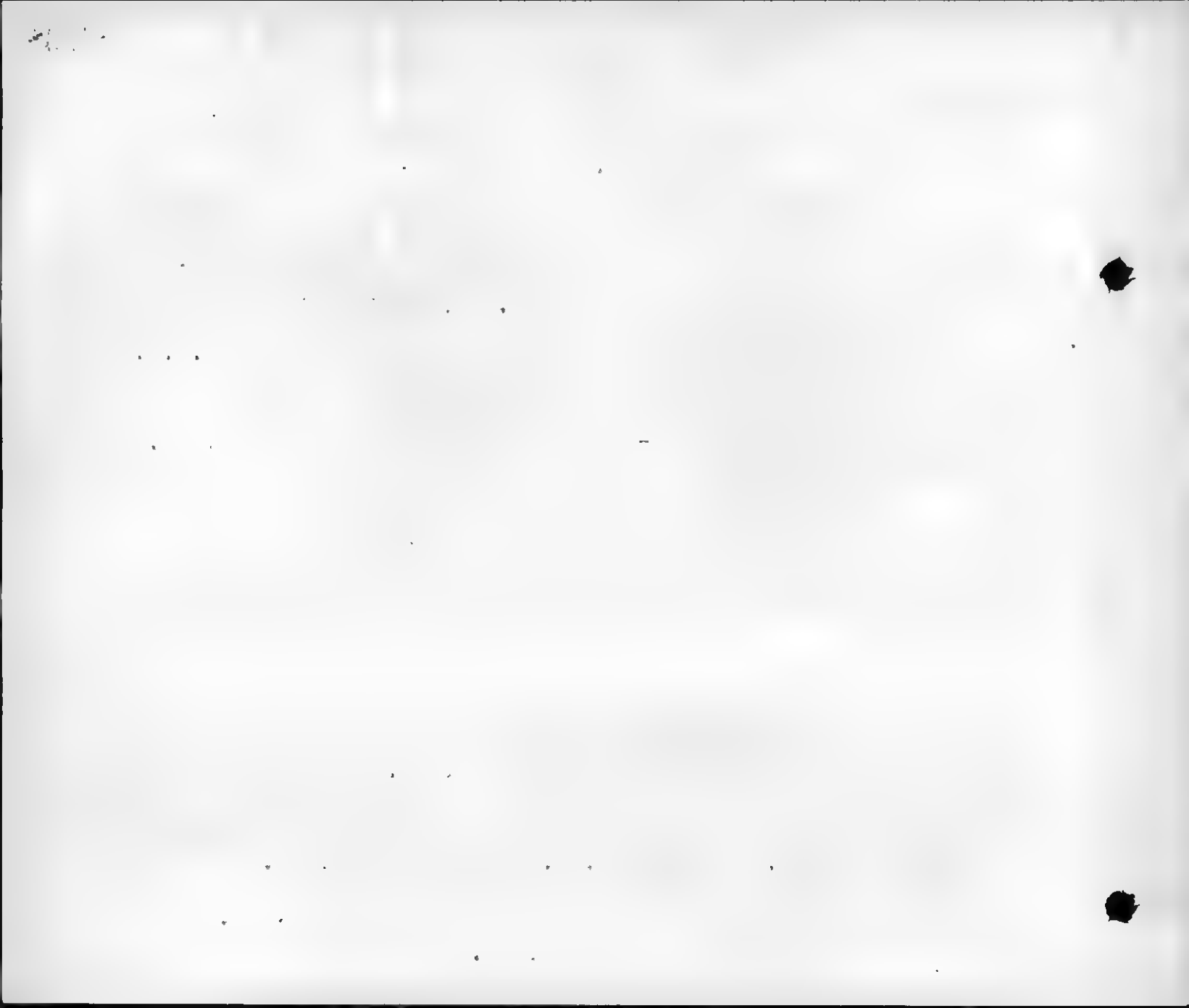
03304

3332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 54 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Gemmell Last Gemmell				4. DATE OF DEATH Month March Day 10 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26, 1886	
9. AGE (In years last birthday) 74 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Green House		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME (First name not known) Gemmell			
14. MOTHER'S MAIDEN NAME Katherine Huthhinson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 213-10-7707				17. INFORMANT Teresa Welling Address Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Carcinoma of Esophagus DUE TO (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from December 20, 1959 to March 10, 1960 , that I last saw the deceased alive on March 6, 1960 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. DATE SIGNED 11 Mar 60			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.				Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/1960		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE MAR 14 '60		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03305

Reg. Dist. No.

3343

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>GRANTSVILLE, MD</u>		c. LENGTH OF STAY IN 1b <u>20 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE, MD</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>DORTHEA</u> Last <u>HOOKER</u>				4. DATE OF DEATH Month <u>MAR.</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 8 1908</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEPHONE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SPRINGS MUTUAL</u>		11. BIRTHPLACE (State or foreign country) <u>CONNELLSVILLE, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE YOMMER</u>				14. MOTHER'S MAIDEN NAME <u>IDA B. RINGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>220-254691</u>		17. INFORMANT <u>Maile Hoover</u> Address <u>9203 Oshtan Rd, Balt, 14, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-27-60</u>			
EXAMINER'S NAME (Type) <u>JAMES H FEASTER, JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GRANTSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>GRANTSVILLE GARRETT MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville, Md</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



3333

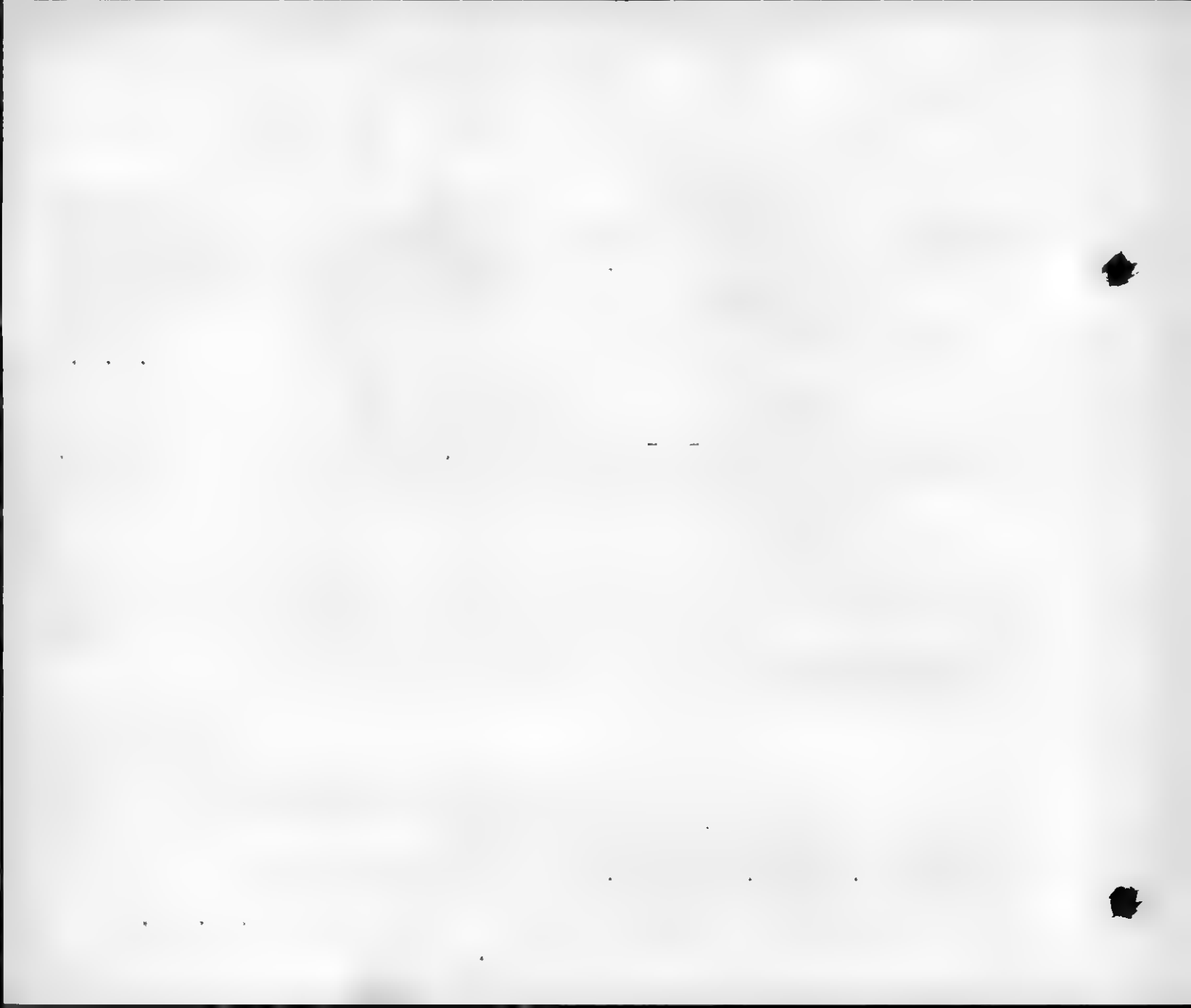
CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 13 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE # 2 DEER PARK		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last KISNER				4. DATE OF DEATH Month MARCH Day 11 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 22, 1888		9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER				10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JACOB KISNER				14. MOTHER'S MAIDEN NAME JAMIMA ENLOW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-01-4891		17. INFORMANT CHARLES E. KISNER		Address ROUTE # 2 DEER PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URemia DUE TO 4 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Generalized DUE TO Years (c) TNCM						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TNCM						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-26 , 19 60 , to 3-11 , 19 60 , that I last saw the deceased alive on 3-10 , 19 60 , and that death occurred at 2:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. James H. Feaster Jr.				ADDRESS (Street, city or town, state) 58 2nd St Oakridge 3-11-60			
PHYSICIAN'S NAME (Type) DR. JAMES H. FEASTER JR.				DATE SIGNED 3-11-60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3/13/1960		Nethken Hill Cemetery		Elk Garden, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE He Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR MAR 14 '60	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 GOODWILL MENNONITE HOME, GRANTSVILLE MD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH KLOTZ		4. DATE OF DEATH Month Day Year MAR 2 1960	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 23 1869
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY BROTHERS HOME	
11 BIRTHPLACE (State or foreign country) GRANTSVILLE MD		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13 FATHER'S NAME CHRIST KLOTZ		14 MOTHER'S MAIDEN NAME MARY POPE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NONE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 10 years 20 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1960 to March 2, 1960 that I last saw the deceased alive on March 1, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE A. Paige Strong M.D.		ADDRESS (Street, city or town, state) Grantsville, Md. DATE SIGNED 3/2/60	
PHYSICIAN'S NAME (Type) A. PAIGE STRONG			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/4/60	22c. NAME OF CEMETERY OR CREMATORY ACCIDENT	22d. LOCATION (City, town, or county) (State) ACCIDENT GARRETT Co, MD
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman, GRANTSVILLE, MD		24a. REC'D BY REGISTRAR MAR 10 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03308

Reg. Dist. No.

3334

1. PLACE OF DEATH a. COUNTY <u>Preston</u> <u>Garrett</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission). a. STATE <u>West Virginia</u> b. COUNTY <u>Preston</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN Tb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rowlesburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>Wilson Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Dianne</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 20, 1954</u>		9. AGE (In years last birthday) <u>6</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>29</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grade School</u>		11. BIRTHPLACE (State or foreign country) <u>Terra Alta, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harley Melvin Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Elouise Virginia Yonker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Elouise V. Lewis, Rowlesburg, W.Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lower Nephron Nephrosis; Anasarca;</u> DUE TO <u>Hydrothorax; Ascites</u> Conditions, if any, which gave rise to immediate cause (b) <u>3rd & 4th degree burns (approx. 50% of body). 3 days</u> (c) <u>3rd & 4th degree burns (approx. 50% of body). 3 days</u> DUE TO <u>3rd & 4th degree burns (approx. 50% of body). 3 days</u> DUE TO <u>3rd & 4th degree burns (approx. 50% of body). 3 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atelectasis; terminal, due to aspiration of stomach contents</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Clothing caught fire from gas heating stove.</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:45 a.m. 3/27/60 19</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rowlesburg, Preston, West Va.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feister Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James H. Feister Jr. M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 29, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal & Burial</u>		22b. DATE THEREOF <u>4/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Terra Alta Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Terra Alta, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William F. D. No. A 7220</u>				24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kram</u>	

MEDICAL CERTIFICATION

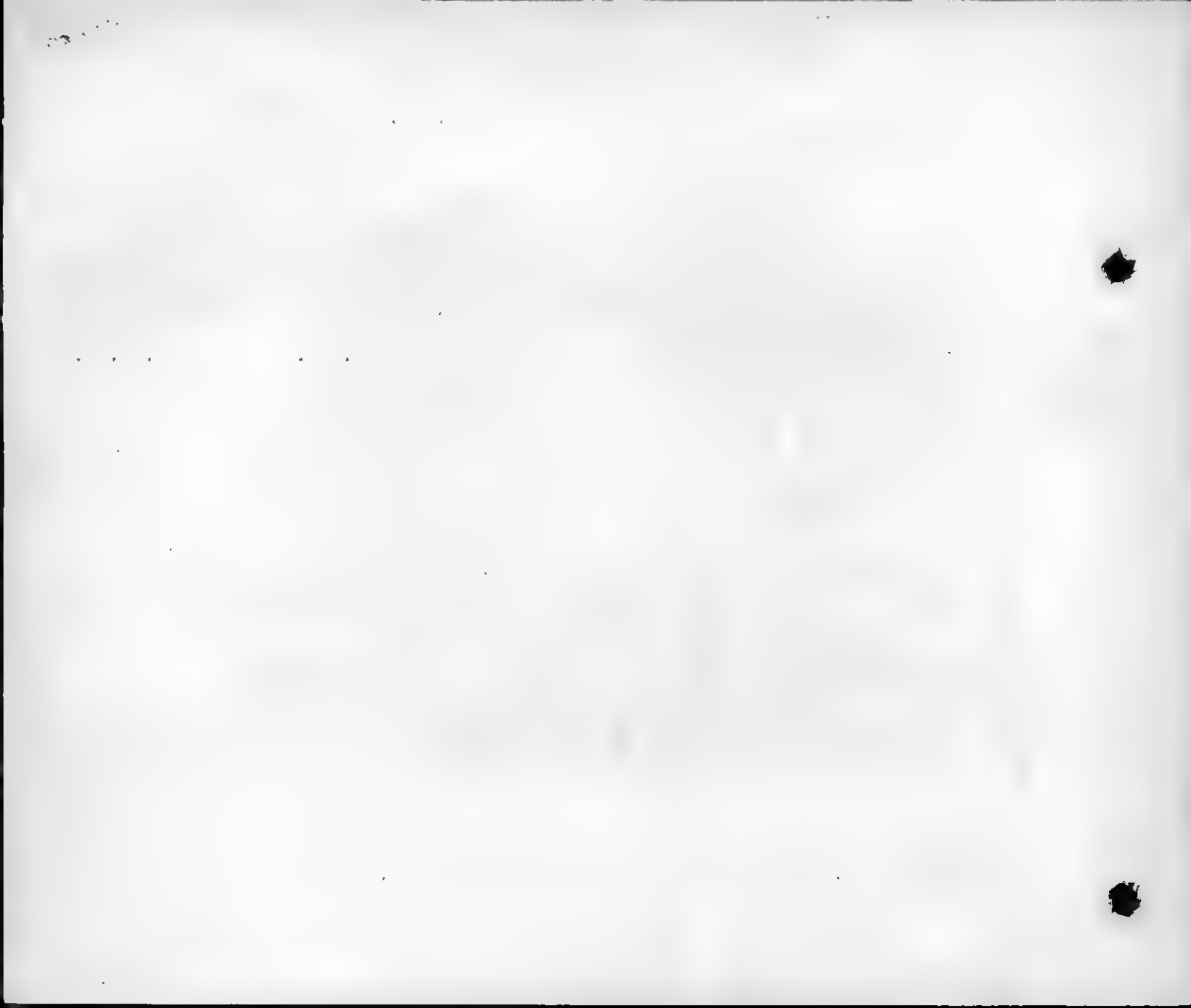
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



3345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GRANTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GRANTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>HENRY</u> Last <u>POLEMAN</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 21/1869</u>
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>GARRETT Co, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY POLEMAN</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINA CHRISTNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Lawrence Poleman, RD, Salisbury Pa</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>60</u> , to <u>March 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 1</u> , 19 <u>60</u> , and that death occurred at <u>12:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Paige Strong</u> M.D.		ADDRESS (Street, city or town, state) <u>Grantsville, Md.</u> DATE SIGNED <u>3/4/60</u>	
PHYSICIAN'S NAME (Type) <u>A. Paige Strong</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT ZION</u>	22d. LOCATION (City, town, or county) (State) <u>STAR ROUTE FROSTBURG GARRETT Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville, Md</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 10 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

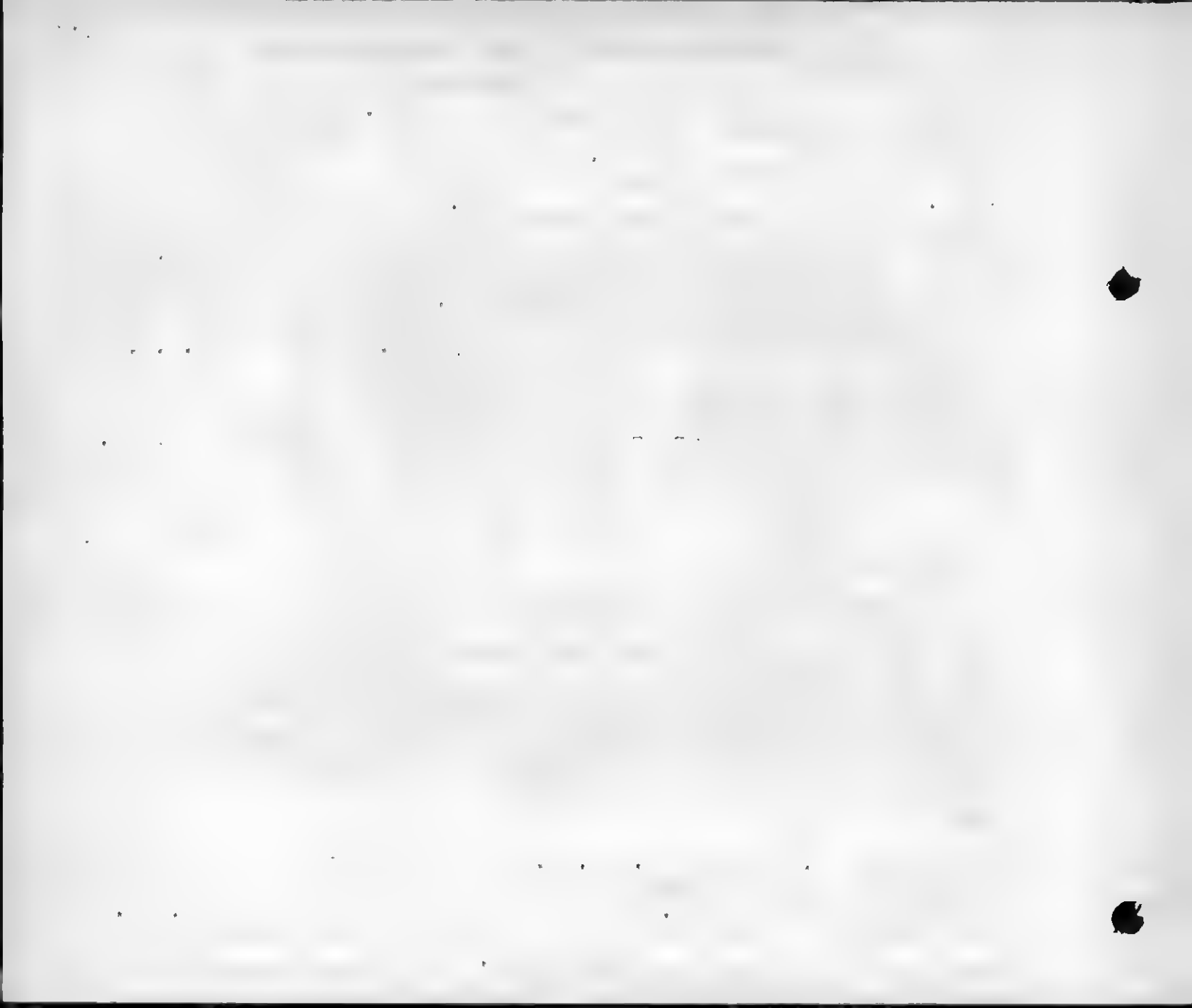
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03311

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton c. LENGTH OF STAY IN lb 68 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 Mi. S E Swanton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton d. STREET ADDRESS 5 Mi. S E Swanton e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Rhodes		4. DATE OF DEATH Month March Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 6 Days 10	IF UNDER 24 HRS. Hours 10 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mines	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jackson Rhodes		14. MOTHER'S MAIDEN NAME Emily Bray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war and dates of service) WW #1		16. SOCIAL SECURITY NO. 213-18-2907	
17. INFORMANT Dorsey Paugh Address R D #1 Swanton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation, acute 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis, moderate (c) stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0			INTERVAL BETWEEN ONSET AND DEATH hours years.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James H. Feaster Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR 3-5-60		24b. REGISTRAR'S SIGNATURE Carlton S. Huns	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files.



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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

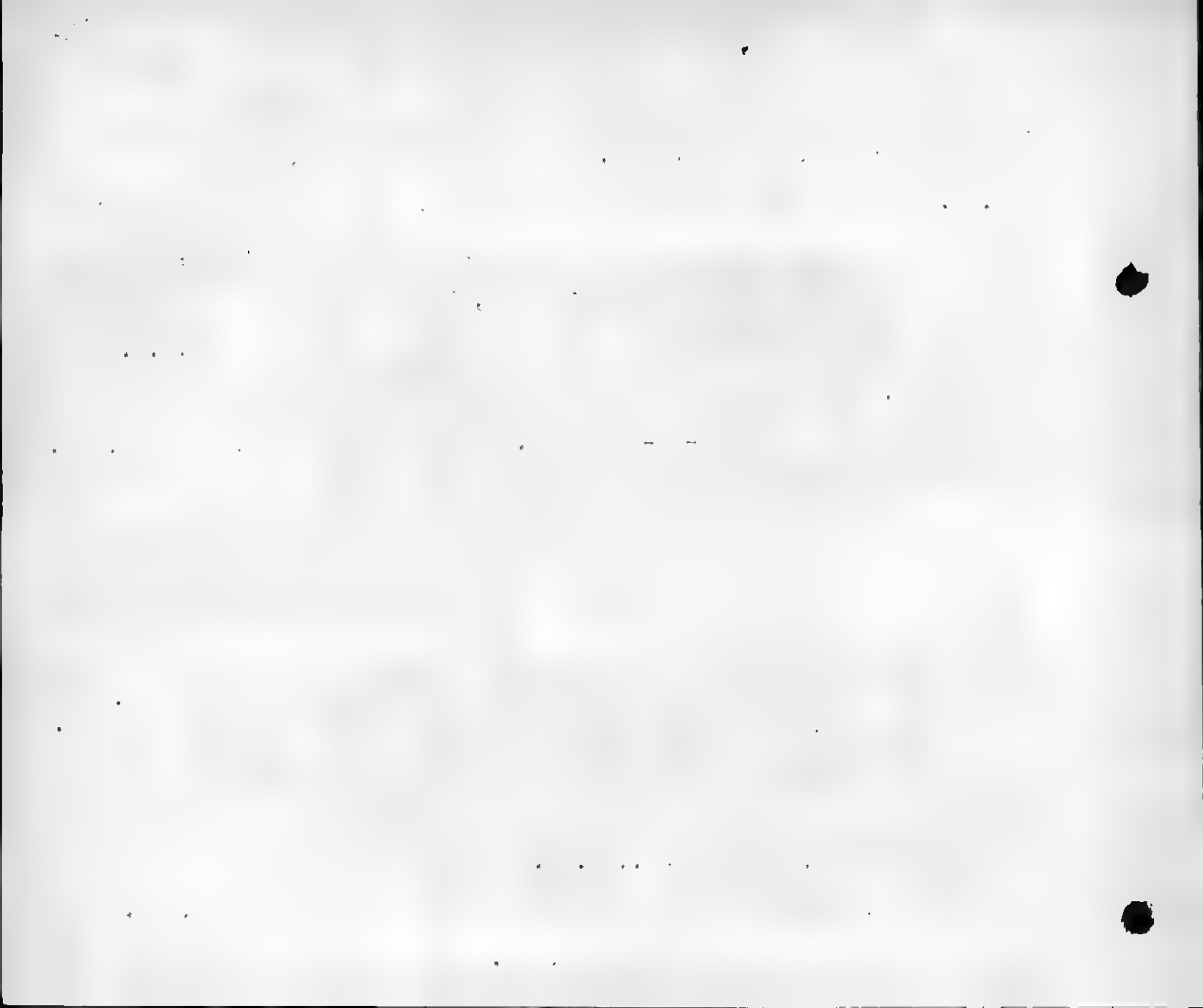
334

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland,</u> c. LENGTH OF STAY IN 1b <u>55 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R. D. 2, near Red House</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland,</u> d. STREET ADDRESS <u>R D #2, near Red House</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harman Casper Rolf</u>		4. DATE OF DEATH Month Day Year <u>March 2, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1904</u>
9. AGE (in years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Rolf</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Blamble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>312-24-2420</u>	
17. INFORMANT <u>Mrs. Harman Rolf</u>		Address <u>R D 2, Oakland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Farm tractor upset on slippery ground and pinned head</u>	
20c. TIME OF INJURY Month, Day, Year <u>1</u> Hour <u>2-2-60</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>	20f. (City or town) <u>Rural Oakland Garr. Md.</u> (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>		DATE SIGNED <u>2-3-60</u>	
EXAMINER'S NAME (Type) <u>James H. Feaster Jr., M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/5/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Red House Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Garrett County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Lighton</u>		ADDRESS <u>Oakland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3348

CERTIFICATE OF DEATH

03313

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X FRIENDSVILLE, MD	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last WILLIAM EDWARD SWAUGER		4. DATE OF DEATH Month Day Year MAR. 1 1960	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 20, 1881
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER-RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) BITTINGER, GARRETT CO MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME SAMUEL SWAUGER		14. MOTHER'S MAIDEN NAME REBECCA HARMON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 220-03-3804	
17. INFORMANT Address Mrs. Edna Livingood Friendsville Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 610X DUE TO CARDIORESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypostatic Pneumonitis (c) Prostration due to Aging.		INTERVAL BETWEEN ONSET AND DEATH 6 WKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN , 1960, to FEB 29, 1960 , that I last saw the deceased alive on FEB 29, 1960 , and that death occurred at 1230 PM , from the causes and on the date stated above			
ACTUAL SIGNATURE Pedro Rivera M.D.		ADDRESS (Street, city or town, state) FRIENDSVILLE DATE SIGNED 3-2-60	
PHYSICIAN'S NAME (Type) PEDRO RIVERA			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/3/60	
22c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE		22d. LOCATION (City, town, or county) (State) GRANTSVILLE GARRETT CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman		24a. REC'D BY REGISTRAR MAR 10 60	
ADDRESS Grantsville Md		24b. REGISTRAR'S SIGNATURE Robert S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03314

3326

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u> <u>Ox 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cuppert Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>M. Thompson</u> Last			4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/1872</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hardy County, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Newhouse</u>				14. MOTHER'S MAIDEN NAME <u>(unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT <u>Mr. Emory Thompson</u> Address <u>McCoole, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Change</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Melancholia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1</u> , 19 <u>59</u> , to <u>March 16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 14</u> , 19 <u>60</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>E. J. Baumgartner</u> M.D. <u>2500 Du St</u> <u>3/18/60</u> PHYSICIAN'S NAME (Type) <u>E. J. BAUMGARTNER M.D.</u> <u>Oakland Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hayle Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Petersburg, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Blaine Shaffer</u>				ADDRESS <u>Petersburg, W. Va.</u>		24a. REC'D BY REGISTRAR <u>APR 4 60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

CERTIFICATE OF DEATH

1. Name of deceased: William J. Smith

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15, 1910

5. Place of death: Home

6. Cause of death: Heart Disease

7. Signature of physician: Dr. J. H. Smith

8. Signature of registrar: J. H. Smith

9. Date of registration: Jan 15, 1910

10. Place of registration: Boston

3349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First OLIVE Middle MYRTLE Last ZELER		4. DATE OF DEATH Month MAR. Day 10 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 30, 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) GROVE CITY, PA		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME JOHN A. BARR		14. MOTHER'S MAIDEN NAME FIRST NAME UNKNOWN WALLS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Charles Zeller, Grantsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebrovascular accident DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1958 to March 12, 1960 that I last saw the deceased alive on March 9, 1960 , and that death occurred at 3:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Paige Strong		M.D. Grantsville DATE SIGNED 3/11/60	
PHYSICIAN'S NAME (Type) A PAIGE STRONG			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/12/60	22c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL	22d. LOCATION (City, town, or county) (State) FROSTBURG ALLEGANY MD
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman, Grantsville, Md		24. REC'D BY REGISTRAR MAR 14 '60 DATE	
24b. REGISTRAR'S SIGNATURE Charles E. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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